CANNON BUILDING
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DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF EXAMINERS IN OPTOMETRY

TELEPHONE: (302) 744-4500
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WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF OPTOMETRIST LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held an optometry license.

Licensing Authority:_____ Address:_____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____

Applicant completes this section	Last Name:_____ First:_____ Middle: _____ SSN:_____ Date of Birth:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ **I am applying for licensure as a Therapeutic Optometrist in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Examiners in Optometry.** **Applicant Signature:** _____ Date: _____
Licensing authority completes this section	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (month/day/year): _____ Expiration Date : _____(month/day/year)_____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, enclose a certified copy of the Board Order with this license verification.**
AFFIX OFFICIAL SEAL HERE	**I certify that the information above is an accurate account of this person's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**